

LONG-TERM CARE INSURANCE IMPROVEMENT AND ACCOUNTABILITY ACT

AUGUST 12 (legislative day, AUGUST 5), 1992.—Ordered to be printed

Mr. KENNEDY, from the Committee on Labor and Human
Resources, submitted the following

REPORT

[To accompany S. 2141]

The Committee on Labor and Human Resources, to which was referred the bill (S. 2141), to amend the Public Health Service Act to improve the quality of long-term care insurance through the establishment of Federal standards, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill, as amended, do pass.

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I. SUMMARY OF THE BILL

Under this bill, the NAIC would be responsible for establishing standards incorporating the requirements of the bill, which States would then be required to adopt. The proposal would also establish an advisory committee to the Secretary of the Department of Health and Human Services that would include consumers, industry, and agent representatives.

This bill would prohibit several marketing and sales practices:

A. Twisting/churning, which occurs when individuals are pressured into changing policies in order for an agent to receive a new sales commission.

B. High pressure tactics used by agents to threaten or capitalize on the fear of financial catastrophe associated with the cost of financing long-term care.

C. Cold lead advertising, which refers to obtaining leads for the sale of insurance by deceptive means, e.g. conducting a raffle.

There is evidence of problems with agents who fill in medical histories incorrectly. If an agent incorrectly answers these questions on behalf of an applicant, an applicant could face the possibility of having claims denied at a later date on the basis that the applicant misrepresented his or her health status at the time of application. The bill would prohibit an agent from knowingly completing medical histories with misleading information.

The sale of long-term care insurance to an individual who is eligible for Medicaid would be prohibited.

The bill would establish standards for the level of commissions or other compensation for new sales of either no more than 200 percent of second year commissions or compensation or no more than 50 percent of the premium paid on the first year policy. (This standard would be in effect until the NAIC developed standards on compensation.) This provision will decrease the amount of "front-loading" of commissions, which refers to agents earning large commissions for new sales and smaller commissions for policy renewals.

The NAIC would be charged with establishing requirements for long-term care insurance agent training and certification.

Marketing and sales abuses leave consumers vulnerable to purchasing benefit packages that do not guarantee coverage will be there when services are needed. To address this problem, the bill includes two important protections:

(A) Plans must include an offer of inflation protection.

Long-term care policies typically include benefits defined by a specific dollar level, e.g., a daily benefit equal to \$50 per day for nursing home care, as opposed to the number of days covered. Assuming a conservative inflation estimate of 5 percent per year, without inflation protection a long-term care policy would be eroded by 50 percent in just 10 years. This feature would ensure that consumers have adequate information regarding the value of an inflation protection—and what the benefit would cost if they were to buy it initially or upgrade their policy to include the additional protection after a number of years. The bill would also ensure that this benefit provides for increases of not less than 5 percent compounded annually.

(B) All policies will be required to include a nonforfeiture benefit, which conforms to one of the models developed by the NAIC.

Similar to a whole life policy or home mortgage, a nonforfeiture benefit for long-term care insurance would assure that a policy holder did not have to forfeit vested equity in a policy should the policy lapse. Long-term care policies are typically held for many years before their benefits are used. Thus, the possibility of a policy lapsing during this period is significant. For example, assuming a conservative lapse rate of 10 percent per year, only 7 percent of

policies purchased at age 65 are still in force at age 85, when they are most likely to be needed.

When a long-term care insurance policy lapses, the policy holder forfeits a significant amount of equity which has been built up to pre-fund future needs. Individuals often pay into long-term care policies for 10, 15, or 20 years or more only to find that a premium suddenly makes the policy unaffordable. When this happens, policy holders surrender years of premiums plus interest earned and are left with no long-term care protection at all.

Currently, insurance companies have devised their own format for explaining benefit packages, making it difficult for consumers to compare alternative policies. Consumers generally do not have information concerning how much benefits are expected to be worth over time. Nor do they have access to information concerning the reputation and quality of services or products of a particular insurance company or agent.

This bill would require the NAIC to establish a standardized outline of coverage that contains information on the scope and terms of coverage, including: the principal benefits and exclusions under the policy; the effects of inflation on the benefits covered; and a statement that premiums for the policy will not increase by more than a specified percent during any calendar year.

The bill would also require states to make information available to consumers regarding the quality of insurance companies and individual agents, including: complaints received with respect to long-term care insurance policies; the lapse and replacement rates for policies; the number of policy revisions; and the number of claims denied as a percent of claims submitted.

All policies would be required to be guaranteed renewable. Policies could only be canceled for nonpayment of premium with individuals given a three-month grace period.

There is a variety of problems associated with the current lack of standard definitions used for benefits and services as well as the lack of a standard assessment method for determining eligibility for coverage.

The NAIC would be charged with establishing standards to be used in all long-term care insurance policies according to requirements specified in the bill, including: uniform language and definitions for benefits and services; standard benefit packages; limitations on the use of pre-existing condition limitations; standardized assessments and determinations of eligibility for benefits.

Long-term care insurance policies that cover home health would have to meet additional requirements including that such policies may not limit home health benefits to skilled nursing services and that they must provide, at a minimum, benefits for personal care services, adult day care, and respite care.

Under this bill, long-term care insurance policies may not impose prior hospitalization as a prerequisite for the receipt of benefits for nursing home care or home and community-based care.

The NAIC would be charged with issuing minimum guidelines concerning a code of conduct for organizations and associations and their subsidiaries that provide endorsements for long-term care insurance policies.

This bill would establish a grant program for States and national organizations to establish long-term care counselling programs. The bill authorizes \$10 million to be appropriated for a state grant program and \$1 million for national organizations.

This bill would establish a demonstration program to encourage States to improve enforcement efforts.

II. BACKGROUND AND NEED

Three million disabled elderly Americans need home care or nursing home care today. They are unable to perform two or more of the five basic activities of daily living without assistance—bathing, eating, dressing, going to the bathroom, or moving from a bed to a wheelchair.

Of these senior citizens, 1.3 million live in nursing homes and the rest are struggling to survive in their own homes, in their children's homes, or in other community settings. As many as a million younger Americans are similarly disabled.

Large as these figures are, they dramatically understate the need for long-term care. According to studies by the Brookings Institution, between 35 and 50 percent of today's senior citizens will enter a nursing home at some point in their lives.

Long-term care is not just a crisis for the elderly—it is a crisis for their families as well. Few relatives are prepared—either financially or emotionally—to take on the heavy responsibility of providing the care that their loved ones need. Medicare does not cover such costs at all. Because of its means test, assistance from Medicaid does not become available until families have virtually exhausted their life savings.

In recent years, to fill the gap in long-term care, the private insurance industry has begun to offer policies that purport to provide protection. The number of citizens with long-term care policies has doubled in the past 3 years, and several million policies have been sold. But this rapid growth is accompanied by serious problems.

These problems include high rates of lapsed policies, abuses by insurance agents, and decline in the value of policy benefits during the long time elapses between the purchase of a policy and when it is needed.

Too many senior citizens who purchase a policy let it lapse. A recent survey by the Health Insurance Association of America found lapse rates of 12 percent a year. In other words, if a hundred senior citizens buy a long-term care policy at age 65, fewer than two will still have coverage at age 85, when they are most likely to need it.

In addition, agents' commissions are sometimes designed so that up to 70 to 80 percent of their total compensation on a policy is paid up front, at the time of the initial sale. Only 20 to 30 percent is based on policy renewals. The result is to encourage the sale of multiple policies of senior citizens, and discourage the renewal of existing policies. Because of rising costs, policies adequate today are likely to provide only minimal protection when they are needed in the future. A nursing home stay that now costs an average of \$86 a day will cost \$228 twenty years from now, assuming a modest inflation rate of just 5 percent a year. The most recent GAO study

of states' compliance with voluntary standards for inflation protection found that 40 States were not in compliance.

Senior citizens buy long-term care insurance to protect against the worst case—a lengthy stay in a nursing home. Such stays account for the majority of dollars spent on long-term care, and are often needed for Alzheimer's patients. The Alzheimer's Association recently released a study on the inadequacy of even top-of-the-line insurance policies to protect families against the financial devastation of Alzheimer's disease. Long-term care policies must pass the "Alzheimer's test" if families are to receive full value of their long-term care insurance dollar.

In response to similar abuses in so-called "Medigap" policies to protect the elderly against bills not covered by Medicare, Congress passed legislation in 1990 setting basic standards for such policies. Similar legislation is needed now to correct the abuses in private long-term care policies.

III. HISTORY OF LEGISLATION

S. 2141 was introduced in January 1992 by Senator Edward M. Kennedy with Senators Adams and Simon as original co-sponsors and referred to the Committee on Labor and Human Resources.

A hearing was held on S. 2141 by the Labor and Human Resources Committee on April 29, 1992.

IV. VOTES IN COMMITTEE

An amendment in the nature of a substitute was offered by Senator Edward M. Kennedy and Senator Orrin Hatch at an executive session of the Committee on Labor and Human Resources on July 1, 1992. The amendment was adopted unanimously by voice vote and favorably reported to the full Senate, also by voice vote.

V. COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 4, 1992.

Hon. EDWARD M. KENNEDY,
*Chairman, Committee on Labor and Human Resources, U.S. Senate,
Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 2141, the Long-Term Care Insurance Improvement and Accountability Act, as ordered reported by the Senate Committee on Labor and Human Resources on July 1, 1992. Enactment of S. 2141 would not affect direct spending or receipts. Therefore, pay-as-you-go procedures would not apply to this bill.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER,
Director.

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: S. 2141.
2. Bill title: Long-Term Care Insurance Improvement and Accountability Act.
3. Bill status: As ordered reported by the Committee on Labor and Human Resources on July 1, 1992.
4. Bill purpose: To amend the Public Health Service Act to improve the quality of long-term care insurance through the establishment of Federal standards, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995	1996	1997
Estimated authorizations:						
Advisory committee.....	0	(¹)	(¹)	(¹)	(¹)	(¹)
Demonstration Grant Program.....	5	5	5	5	5	0
Grants for information, counseling, and assistance.....	0	11	11	11	0	0
Total estimated authorization	5	16	16	16	5	0
Estimated outlays:						
Advisory committee.....	0	(¹)	(¹)	(¹)	(¹)	(¹)
Demonstration Grant Program.....	0	2	4	5	5	3
Grants for information, counseling, and assistance.....	0	5	10	11	6	1
Total estimated outlays	0	7	14	16	11	4

¹ Less than \$500,000.

Basis of Estimate: S. 2141 would require the Secretary of Health and Human Services to consult with an advisory committee before establishing standards for long-term care insurance policies. The bill authorizes the advisory committee to submit requests to Congress for funds to be appropriated for its operation. Based on the past operating costs of advisory committees of similar size to the one that would be established by S. 2141, CBO estimates that the first-year operating expenses of the committee would be approximately \$250,000. Operating costs in subsequent years are estimated to rise at the projected rate of inflation.

Also, S. 2141 would authorize grants to states to set up demonstration programs to improve the enforcement of the long-term care insurance standards established by the legislation. The bill authorizes \$5 million for these grants for each fiscal year from 1992 through 1996. Because it is late in fiscal year 1992, CBO estimates that no funds would be appropriated for fiscal year 1992 for this program.

Finally, S. 2141 would authorize grants to states and national organizations to establish programs to provide information, counseling, and assistance to individuals who are considering purchasing long-term care insurance. The bill authorizes \$10 million for each fiscal year through 1993 through 1995 for grants to states and \$1 million for each fiscal year from 1993 through 1995 for grants to national organizations.

Estimated outlays assume full appropriation of the authorization levels in fiscal years 1993 through 1996. Estimated outlays are based on spending patterns in similar programs.

6. Pay-as-you-go considerations: The Budget Enforcement Act of 1990 set up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1995. None of the provisions of S. 2141 would affect direct spending or receipts through 1995. Therefore, the bill has no pay-as-you-go implications.

7. Estimated cost to State and local governments: S. 2141 would establish standards for long-term care insurance policies and would require states to incorporate these standards in statutes or regulations. Responsibility for enforcing these standards would be placed with state insurance commissions or other state agencies. States would be required to file annual reports with the Secretary of Health and Human Services on the implementation and enforcement of long-term care insurance standards. No data are available to estimate the cost to state governments of enforcing long-term care insurance standards. The cost of preparing annual reports on enforcement is estimated to be negligible.

8. Estimate comparison: None.

9. Previous CBO estimate: None.

10. Estimate prepared by: Patrick Purcell.

11. Estimate approved by: C.G. Nuckols, Assistant Director for Budget Analysis.

VI. REGULATORY IMPACT STATEMENT

This legislation is not expected to have any significant regulatory impact or impact on any regulatory agency.

VII. SECTION-BY-SECTION ANALYSIS

Section 1. This section states the title of bill as the "Long-Term care Insurance Improvement and Accountability Act".

Section 2. This section amends the Public Health Service Act by changing title XXVII to title XXVIII, and by inserting a new section "Title XXVII-Long-Term Care Insurance Standards" after Title XXVI.

PART A OF THE NEW TITLE XXVII—PROMULGATION OF STANDARDS AND MODEL BENEFITS

New section 2701. Standards

Subsection (a) states that if within 12 months of the date of the enactment of this title, the National Association of Insurance Commissioners (NAIC) promulgates model standards that incorporate the requirements of this title, such standards shall apply as provided in this title. If the NAIC does not promulgate model standards by the deadline, the Secretary shall provide, within 12 months of that deadline, standards that incorporate the requirements of this title and such standards shall apply. However, nothing in this title prevents States from applying standards that provide greater protection to policy holders than the standards set by this title, except that such State standards may not be inconsistent with the requirements of this title.

Subsection (b) states that the application deadline of these standards is the date the State adopts the standards, or 1 year after the first day of the first legislative session that begins after the date

such standard are first established—whichever is earlier. In States identified by the Secretary, in consultation with the NAIC, as requiring legislation other than legislation appropriating funds in order to establish standards, but having a legislature which is not scheduled to meet within 1 year following the beginning of the next regular legislative session in which such legislation may be considered, the date specified in this subsection is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1993. In the case of a State that has a 2-year legislative session, each year of the session shall be deemed as a separate regular session of the State legislature.

Subsection (c) identifies items to be included in the standards promulgated under subsection (a). These standards are: minimum Federal standards for long-term care insurance consistent with the provisions of this title; standards for the enhanced protection of consumers with long-term care insurance; procedures to modify the established standard to expand existing Federal or State long-term care benefits or establish a comprehensive Federal or State long-term care benefit program; and other activities determined appropriate by Congress.

Subsection (d) establishes an advisory committee, chosen by the Secretary. The committee must be composed of: three individuals who are representatives of carriers; three individuals who are representatives of consumer groups; three representatives of providers of long-term care services; three other individuals who are not representatives of carriers or of providers of long-term care services; three other individuals who are not representatives of carriers or of providers of long-term care services and who have expertise in the delivery and financing of such services; and the secretary of Veteran Affairs.

The duties of this committee will be to recommend the appropriate inflationary index to be used with respect to the inflation protection portion of the standards, to recommend the uniform needs assessment mechanism to be used in determining the eligibility of individuals for benefits under a policy, to recommend appropriate standards for benefits under section 2715(c), and to perform other such activities are determined appropriate by the Secretary.

Subsection (f) states that the following provisions of section 1886(e)(6) of the Social Security Act shall apply to the advisory committee as such provisions apply under such section: (1) subparagraph (C) (relating to staffing and administration); (2) subparagraph (D) (relating to compensation of members); (3) subparagraph (F) (relating to access to information); (4) subparagraph (G) (relating to use of funds); (5) subparagraph (H) (relating to periodic GAO audits); and (6) subparagraph (J) (relating to requests for appropriations).

PART B OF NEW TITLE XXVII.—ESTABLISHMENT AND IMPLEMENTATION OF LONG-TERM CARE STANDARDS

New section 2711. Implementation of policy standards

Subsection (a) states that no long-term care insurance policy may be issued, sold, or offered for sale as a long-term care insurance

policy on or after the specified date, unless the Secretary determines that the State has established a regulatory program that provides for the application and enforcement of the declared standards established under section 2701(a), and that complies with the requirements of subsection (b), by the specified date in section 2701(b), and the policy has been approved by the State commissioner or superintendent of insurance. Also, no long-term care policy may be sold after the specified date if in the case that the State has not established such a program, or if the State's regulatory program has been decertified, the policy has not been accepted by the Secretary as meeting the standards established under section 2701(a).

The Secretary shall periodically review the regulatory programs. If these programs fail to meet the declared standards, the program will be given a chance to correct the failings. After that time, if the standards are still not met, the Secretary can assume control over the State, with respect to certifying policies.

For purposes of subsection (a)(1)(A)(ii), the requirements for a State regulatory program are as follows: there should be notice in the annual report under paragraph (5) to the Secretary of cases where such compliance is not secured within such 30-day period.

The enforcement process under each State regulatory program shall provide procedures for people and entities to file written, signed complaints regarding alleged violation of standards; a timely response to violations; the investigation of the most valid complaints, and other alleged violations of standards; and the imposition of appropriate sanctions against those who have violated the set standards.

The State regulatory program must provide consumers with access to complaints filed, but that access is limited to the extent required to protect the confidentiality of individual policyholders.

Each State program shall provide a process for approving or disapproving proposed premium increases or decreases with respect to long-term care policies, and establish a policy to hear public comments before approving such an increase or decrease. No premium increase will be approved unless the proposal is accompanied by an actuarial memo which includes a description of assumptions that justify the increase, and contains such information as may be required under the standards, and is made available to the public.

The requirement for the process of approval of premiums does not apply to a group long-term care insurance policy except that group policies must, pursuant to guidelines developed by the NAIC, provide notice to policyholders and certificate holders of any premium change under such policy. This requirement does not apply to: group conversion policies; the group continuation feature of a group policy if the insurer separately rates employee and continuation coverage; and group policies where the function of the employer is limited solely to collecting premiums and remitting them to the insurer. A state may enact and enforce laws with respect to premium rates or loss ratios for all, including group, long-term care insurance policies.

Each State regulatory program shall submit to the Secretary, an annual report on the implementation and enforcement of the standards in the State.

In a State without a regulatory program, the Secretary shall provide for the enforcement activities under subsection (c). Subsection (c) identifies the procedures that must be included in the regulatory program: file written, signed complaints respecting alleged violations of the requirements of this title; respond on a timely basis to complaints; investigate the most valid complaints, and any other violations. While conducting the investigations, the agents of the Secretary shall have reasonable access to enable them to fully examine evidence.

Before serving an order, the Secretary is required to notify the violator, and upon request made within a reasonable period of time (not less than 30 days from the date of the notice), provide for a hearing respecting the violation. The hearing should be conducted before an administrative law judge, and if no hearing is requested, the Secretary's imposition of the order shall constitute a final and unappealable order.

Agents of the Secretary and administrative law judge shall have necessary access to the evidence of those being investigated. Administrative law judges may subpoena witnesses and evidence as necessary. In case of noncompliance to a subpoena, an appropriate district court may issue an order requiring compliance. Any failure to obey may be punished as contempt in that district court.

After such a hearing, if the administrative law judge finds violations of the title, he shall state his finding, and ask that appropriate action be taken. At that time, the violator should cease any and all acts of noncompliance, and pay a civil penalty in an amount not to exceed \$15,000 in the case of each agent, and \$25,000 in the case of each association, for each violation. In addition, appropriate remedial action may be ordered.

If it is found that the violation was due to reasonable cause and was not done intentionally or by neglect, or if corrective action is taken within 30 days, then no penalty will be handed down. In such a case, the Secretary may waive part or all of the civil money penalty, to the extent that payment of such a penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

The decision of the administrative law judge shall be the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order.

Those found guilty of violations may file a petition with the Court of Appeals within 45 days of the finding. If those found guilty fail to comply with the final order after the opportunity for judicial review, the Secretary shall file suit in any appropriate district court, to seek compliance with the order. In such a suit, the validity and appropriateness of the final order shall not be subject to review.

Subsection (d) gives the Secretary authority to award grants to States to establish programs to improve the enforcement of long-term care insurance standards. To be eligible to receive a grant, a State must submit an application containing whatever information the Secretary requires, including a description of the program for which the State intends to use the amounts provided under the grant. The minimum amount of a grant awarded shall not be less than \$100,000. A State that receives a grant under this subsection shall comply with the evaluation procedures established by the Sec-

retary. The Secretary will use these evaluations to conduct an overall evaluation of the results of the demonstration projects. There are authorized to be appropriated to carry out this subsection, \$5,000,000 for each of the fiscal years 1992 through 1996.

New section 2712. Regulation of sales practices

Subsection (a) relates to the marketing and sale of long-term care insurance policies by agents or associations. The subsection identifies practices that will be considered violations of good faith and fair dealing. Violations of this include: Knowingly making any misleading representation (including inaccurate completion of medical histories) or incomplete or fraudulent comparison of any long-term care insurance policy or insurers for the purpose of inducing a person to retain or effect a change with respect to a policy; employing any method of marketing to induce the purchase of a long-term care policy through force, fight, threat, or undue, pressure, whether explicit; making use directly, or indirectly of any method of marketing which fails to disclose that its purpose is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

Subsection (b) directs the NAIC to recommend financial minimum standards for advising individuals purchasing long-term care insurance policies.

Subsection (c) states that an agent, association, or its subsidiary may not knowingly sell or issue a long-term care policy to anyone who is eligible for Medicaid, or if that policy duplicates coverage already provided in another policy.

Subsection (d) states that an agent or carrier may not sell or issue a service-benefit long-term care insurance policy to an individual knowing that the policy provides for coverage that duplicates coverage already provided in another policy or unless the individual provides a written statement that the coverage does not duplicate other coverage in effect under a service-benefit long-term care insurance policy or will replace another service-benefit insurance policy. In this subsection, the term "service-benefit long-term care insurance policy" means a long-term care insurance policy that provides for benefits based on the kind and amount of services furnished.

Subsection (e) prohibits the sale of policies that reduce, limit, or coordinates the benefits provided under the policy on the basis that the policyholder has or is eligible for other long-term care insurance coverage or benefits.

Subsection (f) prohibits the sale of long-term care policies unless the agent or carriers provides an outline of coverage meeting certain standards to the purchaser or potential purchaser.

Subsection (g) establishes penalties for any agent who offers or sells insurance in violation of this title of imprisonment for not more than 5 years, or a civil money penalty not to exceed \$15,000 for each such violation. If an association or its subsidiary violates any of these terms, it may be fined with a civil money penalty not to exceed \$25,000 for each violation.

Subsection (h) directs the NAIC to establish requirements for long-term care insurance agent training and certification.

New section 2713. Additional responsibilities for carriers

Subsection (a) establishes a requirement that carriers must refund any premiums paid with respect to such policy directly to the applicant if the applicant returns the policy or is denied not later than 30 days after the date of denial or return.

Subsection (b) states that if an application for a long-term care policy is approved, the carrier shall provide the applicant a copy of the policy not later than 30 days after the date of the approval.

Subsection (c) requires that if a claim under a long-term care insurance policy is denied, within 30 days of the denial, the provider must complete a written explanation of the reason for the denial and make available all related medical and patient records. No claim may be denied on the basis of a failure to disclose a condition at the time of issuance of the policy if the application for the policy failed to request information respecting the condition.

Subsection (d) describes reporting information that carriers of long-term care insurance policies shall report to the state director of insurance.

Subsection (e) established standards for agent compensation for the sale of long-term care policies.

New section 2714. Renewability of policies

New Section 2714 outlines the standards for the renewing of long-term care insurance policies.

Subsection (a) states that no long-term insurance policy may be canceled or nonrenewed for any other reason than nonpayment of premium, material misrepresentation, or fraud.

Subsection (b) describes requirements regarding continuation and conversion rights for group policies.

Subsection (c) defines the standards for insurance of long-term care policies. The issuer of such policies shall guarantee coverage to any individual who meets minimum medical underwriting requirements of such policy. The NAIC is directed to establish standards with respect to access of policyholders to upgraded benefits.

Subsection (d) states that a long-term care insurance may not be canceled for nonpayment if the policyholder is determined by a long-term care provider, physician, or other health care provider independent of the issuer of the policy, to be cognitively or mentally incapacitated so as to not make payments in a timely manner. This subsection also includes terms of cancellation: A plan effective the date of the standards established under section 2701(a) may not be canceled because a person is determined to be incapacitated and not making timely payments if the period of nonpayment is in excess of 30 days and the notice of intent to cancel is provided to the policyholder or their representative not less than 30 days prior to such cancellation except that notice may not be provided until the expiration of 30 days after a premium is due and unpaid.

New section 2715. Benefit standards

New Section 2715 elaborates the standards for definitions, terminology, and benefits.

Subsection (a) states that each long-term care insurance policy is to use uniform language, definitions, format for outlines, and must

provide coverage for at least one standard benefits package that includes limitations on amounts of payments per day and lengths of covered stays for certain health care services.

Subsection (b) describes information to be disclosed to all applicants.

Subsection (c) states that a long-term care insurance policy may not condition or limit eligibility for benefits for a kind of services to need for or receipt of any other services; for any benefit on the medical necessity for such benefit; for benefits provided by furnished by licensed or certified providers in compliance with conditions which are in addition to those required for licensure or certification under State law, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC. This subsection also identifies ways in which policies that provide home health care or community-based care may not limit such benefits.

Subsection (c) also states that policies that cover nursing home services, must provide coverage for such benefits with respect to all nursing facilities as defined in section 1919(a) of the Social Security Act. A per diem long-term care insurance policies is defined as one that provides for benefit payments on a periodic basis due to cognitive impairments or loss of functional capacity without regard to the expenses incurred or services rendered during the period to which the payments relate.

Subsection (d) prohibits any different treatment for benefits under the policy in the case of an individual with Alzheimer's disease or with mental retardation or any other cognitive or mental impairment from an individual having another medical condition for which benefits may be made available.

Subsection (e) sets limits for preexisting condition exclusions and defines terms and conditions for preexisting conditions. A long-term care insurance policy may not exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed more than 6 months before the issuance of the policy or for a loss of confinement that begins within 6 months following the effective date of the person's coverage.

Subsection (f) describes the requirements concerning eligibility for benefits. Each policy must describe the level of benefits available under the policy and specify the impairment levels required in order to receive benefits under the policy. In order to submit a claim, each policyholder shall have a professional functional assessment. Such assessment may not be conducted by any individual who has a controlling interest in the issuing of the policy. Each long-term care insurance policy shall be subject to final claims review except that issues concerning an individual's level of impairment as determined by a professional assessment, shall be subject to a separate appeals process.

Subsection (g) specifies that each long-term care insurance policy must offer the option of inflation protection to policyholders. The subsection further defines the kind of inflation protection that must be offered. Carriers are required to include specific information in the outline of coverage that illustrates the effect of inflation and the impact on the premium cost if a person purchases inflation

protection initially or delays purchasing such protection until a later time. The carrier must also allow for increases in benefits that account for anticipated increases in costs of long-term services, and follow guidelines which must be included in the outline of coverage. Inflation protection may only not be included when formally rejected by the policyholder in written form.

New section 2716. Nonforfeiture

If a policy lapses after the policy has been in effect for a minimum period, the policy must provide nonforfeiture benefits as determined appropriate by the NAIC; the benefits must increase according to the policyholder's equity in the policy.

New section 2717. Limit of period of contestability and right to return

A carrier may not cancel or renew a long-term care insurance policy or deny a claim under the policy based on fraud or international misrepresentation unless the notice of such is provided within a certain time period to be determined by the NAIC. Each policyholder shall have the right to return the policy within 30 days of the delivery date if not satisfied.

New section 2718. Civil money penalty

Any carrier, association, subsidiary or agent that sells long-term care insurance policies and fails to ascribe to the standards set in sections 2713(a), 2713(b), 2713(c) or (d), 2713(e), 2715(b)(1), or 2715(f) is subject to a penalty of not to exceed \$25,000 for each such violation; for agents, the fine is not to exceed \$15,000 for each violation.

PART C OF NEW TITLE XXVII—LONG-TERM CARE INSURANCE POLICIES,
DEFINITIONS AND ENDORSEMENTS

New section 2721. Long-term care insurance policy defined

Subsection (a) defines "long-term care insurance policy" as any insurance policy offered to designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity prepaid or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than that of an acute care unit of a hospital. These terms include group and individual annuities and life insurance policies or riders that provide directly, or that supplement long-term care insurance; and a policy, rider, or certificate that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

Subsection (b) states that policies may be issued by carriers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, HMO's, and any similar organization otherwise authorized to provide insurance. The term "long-term care insurance policy" does not include any insurance policy, rider, or certificate that is offered primarily to provide basic Medicare supplemental coverage, basic hospitals expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability

income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With respect to life insurance, such term shall not include life insurance policies, riders, or certificate that accelerate the death benefit specifically for one or more of the qualifying event of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

New section 2722. Code of conduct with respect to endorsements

This section directs the NAIC to issue, no later than 1 year after the date of enactment of this title, guidelines to organizations and associations and their subsidiaries, other than employers and labor organizations, that provide endorsements of long-term care insurance policies or permit sale through the organization or association. This subsection defines the minimum standards to be included in the guidelines.

New section 2731. Funding for long-term care insurance information, counseling, and assistance

The Secretary, acting through the Public Health Service, may grant awards to states and national organizations with demonstrated experience for the establishment of programs to provide information, counseling, and assistance relating to the procurement of adequate and appropriate long-term insurance. Grants to States are authorized to be \$10,000,000 for each of the fiscal years 1993-95. Grants to national organizations are to be \$1,000,000 for each of the fiscal years 1993-95.

New section 2732. Definitions

This section defines terms used in this bill

VIII. COMMITTEE VIEWS

The Committee concludes that S. 2141 would be an effective response to the various problems and abuses experienced in the private long-term care insurance market.

The Committee has adopted a similar process of developing, enacting, and enforcing standards for the sale and marketing of private long-term care insurance policies as was included in the Omnibus Budget Reconciliation Act of 1990 with regards to standards for Medicare supplemental coverage, or Medigap policies.

Committee comments on specific sections of the legislation follow:

Section 2701(a)(3). Relation to State law

To promote uniformity and consistency, the bill allows States to adopt standards that are different from the Federal standards, but only if such State standards are not inconsistent with or in conflict with the Federal standards. The Committee seeks to balance the desire of States to regulate in the area of long-term care insurance with one of the objectives of the bill which is to promote uniformity

and consistency among the States in the regulation of long-term care insurance. In this provision, the Committee intends to prohibit States from adopting standards that would prevent insurers from complying with the provisions of this bill or that would provide for a lower level of protection to consumers.

The legislation permits States to adopt standards that provide greater protection to policyholders. The Committee intends that States be allowed to adopt standards, for example, for higher loss ratios or long-term care insurance policies or to require that all policies include a benefit to protect against the effects of inflation.

The Committee intends that his bill shall in no way restrict a State's ability to provide a private right of action with respect to matters affecting long-term care insurance policies.

Section 2711(b)(5). Annual reports

States with approved regulatory programs will be required to file an annual report with the Secretary for the purpose of demonstrating compliance with the requirements of the Act. The annual report required under subsection (b) should be sufficiently detailed to provide the Secretary with an accurate overview of the state's regulatory program and to inform the Secretary of any material changes in law or practice related to long-term car insurance. The report is not intended to be administratively burdensome or to require reporting about specific policies, complaints or other regulatory matters unless specifically required by the Act, such as issues pertaining to 30-day violations.

Section 2712(b). Regulation of sales practices

The Committee believes that private long-term care insurance should not be purchased by persons at lower levels of income and assets. The Committee recognizes that individuals make purchase decisions depending upon their personal and financial circumstances. Therefore, the Committee intends that financial minimum standards be advisory in nature and recognize an individual's personal circumstances. The Committee does not intend to prohibit States from setting minimum financial standards for the sale of private long-term care insurance, as was done recently by the State of New York.

Section 2712(d). Prohibition of sale or issuance of duplicate service benefit policies

The legislation intends to provide protection to consumers from the sale or issuance of insurance that an agent knows provides protection already held by a person and coordinates benefits, thus rendering the insurance of no value to the individual. While the provision specifically permits the sale of replacement policies, the sale or issuance of addition long-term care insurance policies is not, per se, prohibited where another policy is sold or issued to a person to supplement benefits under an existing policy. For example, a consumer may wish to purchase another policy to combine coverage where benefits under the additional policy are fully payable without regard to other long-term care benefit coverage.

Section 2713(e). Additional responsibilities for carriers

The Committee intends that the total compensation for the sale of the first year of a long-term care policy not exceed either 200 percent of the commission or other compensation paid for selling or servicing the policy in the second year or 50 percent of the premium paid on the first year policy.

Section 2714(c)(2). Upgrade for current policies

The Committee believes that all policyholders should be treated fairly. Thus, the Committee expects that the NAIC will develop guidelines on the use of medical underwriting at the time of a policy benefit upgrade so that existing insureds apply for new policies or coverage shall not be required to meet underwriting criteria more stringent than those that are applied to new prospective insureds who are subject to underwriting.

Section 2715(a). Benefit standards

Given the variation in licensing requirements and type of provider services available in home health care settings, the Committee intends that the NAIC should develop minimum standards for defining long-term services and providers. Minimum standards should assure that all significant terms (including services types, provider and facility types and ADLs) are clearly defined at the point of sale and in the policy or certificate. The Committee expects that the minimum standard should be described by the NAIC in a manner to prohibit the use of restrictive terms. For example, the NAIC should consider an approach that provides that if the policy defines the kind of facility, service, or provider, then such terms shall not be defined more restrictively than the definitions provided by the NAIC.

The Committee intends for the NAIC to establish at least one standard benefits package that all carriers of long-term care insurance must offer in addition to any other long-term care insurance plans they offer. In recommending a standard package of benefits, the NAIC should take into consideration the differences between service-benefit design plans and disability design plans.

Section 2715(c)(4). Per diem policies

Many long-term care policies are service-based, i.e. they require the receipt of professional long-term care services in recognized facilities or in an individual's home. However, a growing number of plan designs include the per diem or disability model. These policies pay a fixed daily (or other specified period) amount based upon cognitive impairment or a loss of functional capacity or disability. Once the disability is established they pay a fixed amount regardless of the receipt of professional services, even where care is rendered by an informal care giver. This paragraph is not intended to prohibit different payment amounts based on providing services in different settings.

The Committee intends that this legislation recognize these product variations. Thus, minimum home health care services or nursing home services should only be required of "service-benefit" poli-

cies because “per diem” policies pay regardless of the kind of service and the payment can be used for any kind of provider.

Section 2715(f). Eligibility for benefits

The Committee intends that the claims review process under paragraph (3) could include a review of an individual’s functional assessment performed under paragraph (2).

Section 2716. Nonforfeiture

The Committee understands that the NAIC is currently working on the form of a mandatory nonforfeiture benefit. It is the Committee’s view that long-term care insurance should not be used as a savings instrument. Consequently, cash payouts are generally not an appropriate form for a nonforfeiture benefit.

Because the non-forfeiture benefit increases the policy’s value, it also causes a rise in the premium. The Committee would like to see a minimum benefit that strikes a balance between the size of the benefit and its costs, so that long-term care insurance policies are as affordable as possible.

Section 2722: Code of conduct with respect to endorsements

The Committee intends to provide guidelines to protect consumers from instances where some organizations or associations endorse long-term care policies that do not meet minimum standards, or where some organizations or associations providing endorsements are created for misleading or deceptive purposes. The guidelines provide that an endorsing organization or association must know the product it is endorsing, and in so knowing the product also assist consumers in making an informed decision. The guidelines also provide that an endorsing organization or association must disclose sufficient information about the nature of the organization or association and its relationship, financial or otherwise, with the long-term care insurer to permit a consumer to make an informed decision about the value of the endorsement. Failure to follow such guidelines should be treated as unfair sales practices.

IX. CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * *

PART D—NATIONAL LIBRARY OF MEDICINE

Subpart 1—General Provisions

PURPOSE, ESTABLISHMENT, AND FUNCTIONS OF THE NATIONAL LIBRARY
OF MEDICINE

SEC. 465. (a) * * *

* * * * *

(f) Section [2701] 2801 shall be applicable to the acceptance and administration of gifts made for the benefit of the Library or for carrying out any of its functions, and the Board of Regents shall make recommendations to the Secretary relating to establishment within the Library of suitable memorials to the donors.

* * * * *

GIFTS

SEC. 497. The Secretary may, in accordance with section [2701] 2801 accept conditional gifts for the National Institutes of Health or a national research institute or for the acquisition of grounds or for the erection, equipment, or maintenance of facilities for the National Institutes of Health or a national research institute. Donations of \$50,000 or over for the National Institutes of Health or a national research institute for carrying out the purposes of this title may be acknowledged by the establishment within the National Institutes of Health or a national research institute of suitable memorials to the donors.

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TITLE XXVII—LONG-TERM CARE INSURANCE STANDARDS

PART A—PROMULGATION OF STANDARDS AND MODEL BENEFITS

SEC. 2701. STANDARDS.

(a) APPLICATION OF STANDARDS.—

(1) NAIC.—If, within 12 months after the date of the enactment of this title, the National Association of Insurance Commissioners (hereafter in this title referred to as the "NAIC") promulgates model standards that incorporate the requirements of this title, such standards shall apply as provided in this title.

(2) DEFAULT.—If the NAIC does not promulgate the model standards under paragraph (1) by the deadline established in that paragraph, the Secretary shall promulgate, within 12 months after such deadline, a regulation that provides standards that incorporate the requirements of this title and such standards shall apply as provided for in this title.

(3) RELATION TO STATE LAW.—Nothing in this title shall be construed as preventing a State from applying standards that provide greater protection to policyholders of long-term care insurance policies than the standards promulgated under this

title, except that such State standards may not be inconsistent or in conflict with any of the requirements of this title.

(b) DEADLINE FOR APPLICATION OF STANDARDS.—

(1) **IN GENERAL.**—Subject to paragraph (2), the date specified in this subsection for a State is—

(A) the date the State adopts the standards established under subsection (a)(1); or

(B) the date that is 1 year after the first day of the first regular legislative session that begins after the date such standards are first established under subsection (a)(2);
whichever is earlier.

(2) **STATE REQUIRING LEGISLATION.**—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(A) requiring State legislation (other than legislation appropriating funds) in order for the standards established under subsection (a) to be applied; but

(B) having a legislature which is not scheduled to meet within 1 year following the beginning of the next regular legislative session in which such legislation may be considered;

the date specified in this subsection is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1993. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(c) ITEMS INCLUDED IN STANDARDS.—The standards promulgated under subsection (a) shall include—

(1) minimum Federal standards for long-term care insurance consistent with the provisions of this title;

(2) standards for the enhanced protection of consumers with long-term care insurance;

(3) procedures for the modification of the standards established under paragraph (1) in a manner consistent with future laws to expand existing Federal or State long-term care benefits or establish a comprehensive Federal or State long-term care benefit program; and

(4) other activities determined appropriate by Congress.

(d) CONSULTATION.—In establishing standards and models of benefits under this section, the Secretary shall provide for and consult with an advisory committee to be chosen by the Secretary, and composed of—

(1) three individuals who are representatives of carriers;

(2) three individuals who are representatives of consumer groups;

(3) three representatives who are representatives of providers of long-term care services;

(4) three other individuals who are not representatives of carriers or of providers of long-term care services and who have expertise in the delivery and financing of such services; and

(5) the Secretary of Veterans Affairs.

(e) **DUTIES.**—The advisory committee established under subsection (d) shall—

(1) recommend the appropriate inflationary index to be used with respect to the inflation protection benefit portion of the standards;

(2) recommend the uniform needs assessment mechanism to be used in determining the eligibility of individuals for benefits under a policy;

(3) recommend appropriate standards for benefits under section 2715(c); and

(4) perform such other activities as determined appropriate by the Secretary.

(f) **ADMINISTRATIVE PROVISIONS.**—The following provisions of section 1886(e)(6) of the Social Security Act shall apply to the advisory committee chosen under subsection (d) in the same manner as such provisions apply under such section:

(1) Subparagraph (C) (relating to staffing and administration).

(2) Subparagraph (D) (relating to compensation of members).

(3) Subparagraph (F) (relating to access to information).

(4) Subparagraph (G) (relating to use of funds).

(5) Subparagraph (H) (relating to periodic GAO audits).

(6) Subparagraph (J) (relating to requests for appropriations).

PART B—ESTABLISHMENT AND IMPLEMENTATION OF LONG-TERM CARE INSURANCE POLICY STANDARDS

SEC. 2711. IMPLEMENTATION OF POLICY STANDARDS.

(a) **IN GENERAL.**—

(1) **REGULATORY PROGRAM.**—No long-term care policy (as defined in section (2721)) may be issued, sold, or offered for sale as a long-term care insurance policy in a State on or after the date specified in section 2701(b) unless—

(A) the Secretary determines that the State has established a regulatory program that—

(i) provides for the application and enforcement of the standards established under section 2701(a); and

(ii) complies with the requirements of subsection (b); by the date specified in section 2701(b), and the policy has been approved by the State commissioner or superintendent of insurance under such program; or

(B) if the State has not established such a program, or if the State's regulatory program has been decertified, the policy has been certified by the Secretary (in accordance with such procedures as the Secretary may establish) as meeting the standards established under section 2701(a) by the date specified in section 2701(b).

For purposes of this subsection, the advertising or soliciting with respect to a policy, directly or indirectly, shall be deemed the offering for sale of the policy.

(2) **REVIEW OF STATE REGULATORY PROGRAMS.**—The Secretary periodically shall review regulatory programs described in paragraph (1)(A) to determine if they continue to provide for the application and enforcement of the standards and procedures es-

established under section 2701(a) and (b). If the Secretary determines that a State regulatory program no longer meets such standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the Secretary shall assume responsibility under paragraph (1)(B) with respect to certifying policies in the State and shall exercise full authority under section 2701 for carriers, agents, or associations or its subsidiary in the State plans in the State.

(b) **ADDITIONAL REQUIREMENTS FOR APPROVAL OF STATE REGULATORY PROGRAMS.**—For purposes of subsection (a)(1)(A)(ii), the requirements of this subsection for a State regulatory program are as follows:

(1) **ENFORCEMENT.**—The enforcement under the program—

(A) shall be designed in a manner so as to secure compliance with the standards within 30 days after the date of a finding of noncompliance with such standards; and

(B) shall provide for notice in the annual report required under paragraph (5) to the Secretary of cases where such compliance is not secured within such 30-day period.

(2) **PROCESS.**—The enforcement process under each State regulatory program shall provide for—

(A) procedures for individuals and entities to file written, signed complaints respecting alleged violations of the standards;

(B) responding on a timely basis to such complaints;

(C) the investigation of—

(i) those complaints which have a reasonable probability of validity, and

(ii) such other alleged violations of the standards as the program finds appropriate; and

(D) the imposition of appropriate sanctions (which include, in appropriate cases, the imposition of a civil money penalty as provided for in section 2718) in the case of a carrier, agent, or association or its subsidiary determined to have violated the standards.

(3) **CONSUMER ACCESS TO COMPLIANCE INFORMATION.**—

(A) **IN GENERAL.**—A State regulatory program must provide for consumer access to complaints filed with the State commissioner or superintendent of insurance with respect to long-term care insurance policies.

(B) **CONFIDENTIALITY.**—The access provided under subparagraph (A) shall be limited to the extent required to protect the confidentiality of the identity of individual policyholders.

(4) **PROCESS FOR APPROVAL OF PREMIUMS.**—

(A) **IN GENERAL.**—Each State regulatory program shall—

(i) provide for a process for approving or disapproving proposed premium increases or decreases with respect to long-term care insurance policies; and

(ii) establish a policy for receipt and consideration of public comments before approving such a premium increase or decrease.

(B) **CONDITIONS FOR APPROVAL.**—No premium increase shall be approved (or deemed approved) under subparagraph (A) unless the proposed increase is accompanied by an actuarial memorandum which—

(i) includes a description of the assumptions that justify the increase;

(ii) contains such information as may be required under the Standards; and

(iii) is made available to the public.

(C) **APPLICATION.**—Except as provided in subparagraph (D), this paragraph shall not apply to a group long-term care insurance policy issued to a group described in section 4(E)(1) of the NAIC Long Term Care Insurance Model Act (effective January 1991), except that such group policy shall, pursuant to guidelines developed by the NAIC, provide notice to policyholders and certificate holders of any premium change under such group policy.

(D) **EXCEPTION.**—Subparagraph (C) shall not apply to—

(i) group conversion policies;

(ii) the group continuation feature of a group policy if the insurer separately rates employee and continuation coverages; and

(iii) group policies where the function of the employer is limited solely to collecting premiums (through payroll deductions or dues checkoff) and remitting them to the insurer.

(E) **CONSTRUCTION.**—Nothing in this paragraph shall be construed as preventing the NAIC from promulgating standards, or a state from enacting and enforcing laws, with respect to premium rates or loss ratios for all, including group, long-term care insurance policies.

(5) **ANNUAL REPORTS.**—Each State regulatory program shall provide for annual reports to be submitted to the Secretary on the implementation and enforcement of the standards in the State, including information concerning violations in excess of 30 days.

(6) **ACCESS TO OTHER INFORMATION.**—The State regulatory program must provide for consumer access to actuarial memoranda provided under paragraph (4).

(7) **DEFAULT.**—In the case of a State without a regulatory program approved under subsection (a), the Secretary shall provide for the enforcement activities described in subsection (c).

(c) **SECRETARIAL ENFORCEMENT AUTHORITY.**—

(1) **IN GENERAL.**—The Secretary shall exercise authority under this section in the case of a State that does not have a regulatory program approved under this section.

(2) **COMPLAINTS AND INVESTIGATIONS.**—The Secretary shall establish procedures—

(A) for individuals and entities to file written, signed complaints respecting alleged violations of the requirements of this title;

(B) for responding on a timely basis to such complaints; and

(C) for the investigation of—

(i) those complaints that have a reasonable probability of validity; and

(ii) such other alleged violations of the requirements of this title as the Secretary determines to be appropriate.

In conducting investigations under this subsection, agents of the Secretary shall have reasonable access necessary to enable such agents to examine evidence of any carrier, agent, or association or its subsidiary being investigated.

(3) HEARINGS.—

(A) *IN GENERAL.*—Prior to imposing an order described in paragraph (4) against a carrier, agent, or association or its subsidiary under this section for a violation of the requirements of this title, the Secretary shall provide the carrier, agent, association or subsidiary with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary by regulation) of the date of the notice, a hearing respecting the violation.

(B) *CONDUCT OF HEARING.*—Any hearing requested under subparagraph (A) shall be conducted before an administrative law judge. If no hearing is so requested, the Secretary's imposition of the order shall constitute a final and unappealable order.

(C) *AUTHORITY IN HEARINGS.*—In conducting hearings under this paragraph—

(i) agents of the Secretary and administrative law judges shall have reasonable access necessary to enable such agents and judges to examine evidence of any carrier, agent, or association or its subsidiary being investigated; and

(ii) administrative law judges, may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing.

In case of contumacy or refusal to obey a subpoena lawfully issued under this subparagraph and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

(D) *ISSUANCE OF ORDERS.*—If an administrative law judge determines in a hearing under this paragraph, upon the preponderance of the evidence received, that a carrier, agent, or association or its subsidiary named in the complaint has violated the requirements of this title, the administrative law judge shall state the findings of fact and issue and cause to be served on such carrier, agent, association, or subsidiary an order described in paragraph (4).

(4) CEASE AND DESIST ORDER WITH CIVIL MONEY PENALTY.—

(A) *IN GENERAL.*—Subject to the provisions of subparagraphs (B) through (F), an order under this paragraph—

(i) shall require the agent, association or its subsidiary, or a carrier—

(I) to cease and desist from such violations; and

(II) to pay a civil penalty in an amount not to exceed \$15,000 in the case of each agent, and not to exceed \$25,000 for each association or its subsidiary or a carrier for each such violation; and

(ii) may require the agent, association or its subsidiary, or a carrier to take such other remedial action as is appropriate.

(B) **CORRECTIONS WITHIN 30 DAYS.**—No order shall be imposed under this paragraph by reason of any violation if the carrier, agent, or association or its subsidiary establishes to the satisfaction of the Secretary that—

(i) such violation was due to reasonable cause and was not intentional and was not due to willful neglect; and

(ii) such violation is corrected within the 30-day period beginning on the earliest date the carrier, agent, association, or subsidiary knew, or exercising reasonable diligence could have known, that such a violation was occurring.

(C) **WAIVER BY SECRETARY.**—In the case of a violation under this title that is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the civil money penalty imposed under subparagraph (A)(i)(II) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

(D) **ADMINISTRATIVE APPELLATE REVIEW.**—The decision and order of an administrative law judge under this paragraph shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this paragraph.

(E) **JUDICIAL REVIEW.**—A carrier, agent, or association or its subsidiary or any other individual adversely affected by a final order issued under this paragraph may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

(F) **ENFORCEMENT OF ORDERS.**—If a carrier, agent, or association or its subsidiary fails to comply with a final order issued under this paragraph against the carrier, agent, association or subsidiary after opportunity for judicial review under subparagraph (E), the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity and appropriateness of the final order shall not be subject to review.

(d) **DEMONSTRATION GRANT PROGRAM.**—

(1) **IN GENERAL.**—The Secretary may award grants to States for the establishment of demonstration programs to improve the

enforcement within such States of long-term care insurance standards applicable under this title.

(2) *APPLICATION*.—To be eligible to receive a grant under paragraph (1), a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the program for which the State intends to use the amounts provided under the grant.

(3) *MINIMUM AMOUNT OF GRANTS*.—The amount of a grant awarded under this subsection shall not be less than \$100,000.

(4) *EVALUATION*.—A State that receives a grant under this subsection shall comply with such evaluation procedures as the Secretary shall by regulation establish. The Secretary shall utilize such evaluations to conduct an overall evaluation of the results of the demonstration programs established under this section.

(5) *AUTHORIZATION OF APPROPRIATIONS*.—There are authorized to be appropriated to carry out this subsection, \$5,000,000 for each of the fiscal years 1992 through 1996.

SEC. 2712. REGULATION OF SALES PRACTICES.

(a) *DUTY OF GOOD FAITH AND FAIR DEALING*.—

(1) *IN GENERAL*.—Each agent (as defined in section 2733) or association that is selling or offering for sale a long-term care insurance policy has the duty of good faith and fair dealing to the purchaser or potential purchaser of such a policy.

(2) *PROHIBITED PRACTICES*.—An agent or association is considered to have violated paragraph (1) if the agent or association engages in any of the following practices:

(A) *TWISTING*.—

(i) *IN GENERAL*.—Knowingly making any misleading representation (including the inaccurate completion of medical histories) or incomplete or fraudulent comparison of any long-term care insurance policy or insurers for the purpose of inducing, or tending to induce, any person to retain or effect a change with respect to a long-term care insurance policy.

(ii) *POLICY REPLACEMENT FORM*.—With respect to any person who elects to replace or effect a change in a long-term care insurance policy, the individual that is selling such policy shall ensure that such person completes a policy replacement form developed by the NAIC. A copy of such form shall be provided to such person and additional copies shall be delivered by the selling individual to the old policy issuer and the new issuer and kept on file for inspection by the State regulatory agency.

(B) *HIGH PRESSURE TACTICS*.—Employing any method of marketing having the effect of, or intending to, induce the purchase of long-term care insurance policy through force, fright, threat or undue pressure, whether explicit or implicit.

(C) *COLD LEAD ADVERTISING*.—Making use directly or indirectly of any method of marketing which fails to disclose

in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(D) **OTHERS.**—Engaging in such other practices determined inappropriate under guidelines issued by the NAIC.

(b) **FINANCIAL STANDARDS.**—The NAIC shall develop recommended financial minimum standards (including both income and asset criteria) for the purpose of advising individuals considering the purchase of a long-term care insurance policy.

(c) **PROHIBITION OF SALE OR ISSUANCE TO MEDICAID BENEFICIARIES.**—An agent, an association, or a carrier may not knowingly sell or issue a long-term care insurance policy to an individual who is eligible for medical assistance under title XIX of the Social Security Act.

(d) **PROHIBITION OF SALE OR ISSUANCE OF DUPLICATE SERVICE BENEFIT POLICIES.**—An agent, association or its subsidiary, or a carrier may not sell or issue a service-benefit long-term care insurance policy to an individual—

(1) knowing that the policy provides for coverage that duplicates coverage already provided in another service-benefit long-term care insurance policy held by such individual (unless the policy is intended to replace such other policy); or

(2) for the benefit of an individual unless the individual (or a representative of the individual) provides a written statement to the effect that the coverage—

(A) does not duplicate other coverage in effect under a service-benefit long-term care insurance policy; or

(B) will replace another service-benefit long-term care insurance policy.

In this subsection, the term “service-benefit long-term care insurance policy” means a long-term care insurance policy which provides for benefits based on the type and amount of services furnished.

(e) **PROHIBITION BASED ON ELIGIBILITY FOR OTHER BENEFITS.**—A carrier may not sell or issue a long-term care insurance policy that reduces, limits or coordinates the benefits provided under the policy on the basis that the policyholder has or is eligible for other long-term care insurance coverage or benefits.

(f) **PROVISION OF OUTLINE OF COVERAGE.**—No agent, association or its subsidiary, or carrier may sell or offer for a sale a long-term care insurance policy without providing to the purchaser or potential purchaser (or representative) an outline of coverage that complies with the standards established under section 2701(a).

(g) **PENALTIES.**—Any agent who sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be imprisoned not more than 5 years, or fined in accordance with title 18, United States Code, and, in addition, is subject to a civil money penalty of not to exceed \$15,000 for each such violation. Any association or its subsidiary or carrier that sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be fined in accordance with title 18, United States Code, and in addition, is subject to a civil money penalty of not to exceed \$25,000 for each violation.

(h) **AGENT TRAINING AND CERTIFICATION REQUIREMENTS.**—The NAIC, shall establish requirements for long-term care insurance agent training and certification that—

(1) specify requirements for training insurance agents who desire to sell or offer for sale long-term care insurance policies; and

(2) specify procedures for certifying agents who have completed such training and who are qualified to sell or offer for sale long-term care insurance policies.

SEC. 2713. ADDITIONAL RESPONSIBILITIES FOR CARRIERS.

(a) **REFUND OF PREMIUMS.**—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is denied or an applicant returns a policy or certificate within 30 days of the date of its issuance pursuant to subsection 2717, the carrier shall refund directly to the applicant, or in the case of an employer to whomever remits the premium, and not by delivery by the agent, not later than 30 days after the date of the denial or return, any premiums paid with respect to such a policy (or certificate).

(b) **MAILING OF POLICY.**—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the carrier shall provide the applicant, or in the case of a group plan the employer, the policy (or certificate) of insurance not later than 30 days after the date of the approval.

(c) **INFORMATION ON DENIALS OF CLAIMS.**—If a claim under a long-term care insurance policy is denied, the carrier shall, within 30 days of the date of a written request by the policyholder or certificate holder (or representative)—

(1) provide a written explanation of the reasons for the denial; and

(2) make available all medical and patient records directly relating to such denial.

Except as provided in subsection (e) of section 2715, no claim under such a policy may be denied on the basis of a failure to disclose a condition at the time of issuance of the policy if the application for the policy failed to request information respecting the condition.

(d) **REPORTING OF INFORMATION.**—A carrier that issues one or more long-term care insurance policies shall periodically (not less often than annually) report, in a form and in a manner determined by the NAIC, to the Commissioner, superintendent, or director of insurance of each State in which the policy is delivered, and shall make available to the Secretary, upon request, information in a form and manner determined by the NAIC concerning—

(1) the long-term care insurance policies of the carrier that are in force;

(2) the most recent premiums for such policies and the premiums imposed for such policies since their initial issuance;

(3) the lapse rate, replacement rate, and rescission rates by policy;

(4) the names of that 10 percent of its agents that—

(A) have the greatest lapse and replacement rate; and

(B) have produced at least \$50,000 of long-term care insurance sales in the previous year; and

(5) the claims denied (expressed as a number and as a percentage of claims submitted) by policy.

Information required under this subsection shall be reported in a format specified in the standards established under section 2701(a). For purposes of paragraph (3), there shall be included (but reported separately) data concerning lapses due to the death of the policyholder. For purposes of paragraph (4), there shall not be included as a claim any claim that is denied solely because of the failure to meet a deductible, waiting period, or exclusionary period.

(e) STANDARDS ON COMPENSATION FOR SALE OF POLICIES.—

(1) *IN GENERAL.*—A carrier that issues one or more long-term care insurance policies may provide a commission or other compensation to an agent or other representative for the sale of such a policy only if the first year commission or other first year compensation to be paid does not exceed 200 percent of the commission or other compensation paid for selling or servicing the policy in the second year, or if the first year commission or other compensation to be paid does not exceed 50 percent of the premium paid on the first year policy, until the NAIC promulgates mandatory standards concerning compensation for the sale of such policies.

(2) *SUBSEQUENT YEARS.*—The commission or other compensation provided for the sale of long-term care insurance policies in years subsequent to the first year of the policy shall be the same as that provided in the second subsequent year and shall be provided for no fewer than 5 subsequent years.

(3) *LIMITATION.*—No carrier shall provide compensation to its agents for the sale of a long-term care insurance policy and no agent shall receive compensation greater than the renewal compensation payable by the replacing carrier on renewal policies if an existing policy is replaced.

(4) *COMPENSATION DEFINED.*—As used in this subsection, the term “compensation” includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy, including but not limited to deferred compensation, bonuses, gifts, prizes, awards, and finders fees.

SEC. 2714. RENEWABILITY STANDARDS FOR ISSUANCE, AND BASIS FOR CANCELLATION OF POLICIES.

(a) *IN GENERAL.*—No long-term care insurance policy may be canceled or nonrenewed for any reason other than nonpayment of premium, material misrepresentation or fraud.

(b) CONTINUATION AND CONVERSION RIGHTS FOR GROUP POLICIES.—

(1) *IN GENERAL.*—Each group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion in accordance with this subsection.

(2) *BASIS FOR CONTINUATION.*—For purposes of paragraph (1), a policy provides a basis for continuation of coverage if the policy maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. A group policy which restricts provision of benefits and services to or contains incentives to use certain providers or facility, may

provide continuation benefits which are substantially equivalent to the benefits of the existing group policy.

(3) **BASIS FOR CONVERSION.**—For purposes of paragraph (1), a policy provides a basis for conversion of coverage if the policy entitles each individual—

(A) whose coverage under the group policy would otherwise be terminated for any reason; and

(B) who has been continuously insured under the policy (or group policy which was replaced) for at least 6 months before the date of the termination;

to issuance of a policy providing benefits identical to, substantially equivalent to, or in excess of, those of the policy being terminated, without evidence of insurability.

(4) **TREATMENT OF SUBSTANTIAL EQUIVALENCE.**—In determining under this subsection whether benefits are substantially equivalent, consideration should be given to the difference between managed care and non-managed care plans.

(5) **GROUP REPLACEMENT OF POLICIES.**—If a group long-term care insurance policy is replaced by another long-term care insurance policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(c) **STANDARDS FOR ISSUANCE.**—

(1) **IN GENERAL.**—

(A) **GUARANTEE.**—An agent, association or carrier that sells or issues long-term care insurance policies shall guarantee that such policies shall be sold or issued to an individual, or eligible individual in the case of a group plan, if such individual meets the minimum medical underwriting requirements of such policy.

(B) **PREMIUM FOR CONVERTED POLICY.**—If a group policy from which conversion is made is a replacement for a previous group policy, the premium for the converted policy shall be calculated on the basis of the insured's age at the inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(2) **UPGRADE FOR CURRENT POLICIES.**—The NAIC shall establish standards, including those providing guidance on medical underwriting and age rating, with respect to the access of individuals to policies offering upgraded benefits.

(d) **EFFECT OF INCAPACITATION.**—

(1) **IN GENERAL.**—

(A) **PROHIBITION.**—Except as provided in paragraph (2), a long-term care insurance policy in effect as of the effective date of the standards established under section 2701(a) may not be canceled for nonpayment if the policy holder is determined by a long-term care provider, physician or other

health care provider, independent of the issuer of the policy, to be cognitively or mentally incapacitated so as to not make payments in a timely manner.

(B) **REINSTATEMENT.**—A long-term care policy shall include a provision that provides for the reinstatement of such coverage, in the event of lapse, if the insurer is provided with proof of cognitive or mental incapacitation. Such reinstatement option shall remain available for a period of not less than 5 months after termination and shall allow for the collection of past due premium.

(2) **PERMITTED CANCELLATION.**—A long-term care insurance policy may be canceled under paragraph (1) for nonpayment if—

(A) the period of such nonpayment is in excess of 30 days; and

(B) notice of intent to cancel is provided to the policyholder or designated representative of the policy holder not less than 30 days prior to such cancellation, except that notice may not be provided until the expiration of 30 days after a premium is due and unpaid.

Notice under this paragraph shall be deemed to have been given as of 5 days after the mailing date.

SEC. 2715. BENEFIT STANDARDS.

(a) **USE OF STANDARD DEFINITIONS AND TERMINOLOGY, UNIFORM FORMAT, AND STANDARD BENEFITS.**—Each long-term care insurance policy shall, with respect to services, providers or facilities, pursuant to standards established under section 2701(a)—

(1) use uniform language and definitions, except that such language and definitions may take into account the differences between States with respect to definitions and terminology used for long-term care services and providers;

(2) use a uniform format for presenting the outline of coverage under such a policy; and

(3) provide coverage for at least one standard benefits package that shall include the limitations on the amount of payments per day and the lengths of covered stays for nursing facility and home health care services;

as prescribed under guidelines issued by the NAIC and periodically updated.

(b) **DISCLOSURE.**—

(1) **OUTLINE OF COVERAGE.**—

(A) **REQUIREMENT.**—Each carrier that sells or offers for sale a long-term care insurance policy shall provide an outline of coverage under such policy that meets the applicable standards established pursuant to section 2701(a), complies with the requirements of subparagraph (B), and is in a uniform format as prescribed in guidelines issued by the NAIC and periodically updated.

(B) **CONTENTS.**—The outline of coverage for each long-term care insurance policy shall include at least the following:

(i) A description of the principal benefits and coverage under the policy.

(ii) A statement of the principal exclusions, reductions, and limitations contained in the policy.

(iii) A statement of the terms under which the policy (or certificate) may be continued in force or discontinued, the terms for continuation or conversion, and any reservation in the policy of a right to change premiums.

(iv) A statement, in bold face type on the face of the document in language that is understandable to an average individual, that the outline of coverage is a summary only, not a contract of insurance, and that the policy (or master policy) contains the contractual provisions that govern, except that such summary shall substantially and accurately reflect the contents of the policy or the master policy.

(v) A description of the terms, specified in section 2717, under which a policy or certificate may be returned and premium refunded.

(vi) Information on national average costs for nursing facility and home health care and information (in graphic form) on the relationship of the value of the benefits provided under the policy to such national average costs and State average costs, where available.

(vii) A statement of the percentage limit on annual premium increases that is provided under the policy pursuant to this section.

(2) **CERTIFICATES.**—A certificate issued pursuant to a group long-term care insurance policy shall include—

(A) a description of the principal benefits and coverage provided in the policy;

(B) a statement of the principal exclusions, reductions, and limitations contained in the policy; and

(C) a statement that the group master policy determines governing contractual provisions.

(3) **LONG-TERM CARE AS PART OF LIFE INSURANCE.**—In the case of a long-term care insurance policy issued as a part of, or a rider on, a life insurance policy, at the time of policy delivery there shall be provided a policy summary that includes—

(A) an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);

(B) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits (if any) for each covered person; and

(C) any exclusions, reductions, and limitations on benefits of long-term care.

(4) **ADDITIONAL INFORMATION.**—The NAIC shall develop recommendations with respect to informing consumers of the long-term economic viability of carriers issuing long-term care insurance policies.

(c) **LIMITING CONDITIONS ON BENEFITS; MINIMUM BENEFITS.**—

(1) **IN GENERAL.**—A long-term care insurance policy may not condition or limit eligibility—

(A) for benefits for a type of services to the need for or receipt of any other services;

(B) for any benefit on the medical necessity for such benefit;

(C) for benefits furnished by licensed or certified providers in compliance with conditions which are in addition to those required for licensure or certification under State law, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC; or

(D) for residential care (if covered under the policy) only—

(i) to care provided in facilities which provide a higher level of care; or

(ii) to care provided in facilities which provide for 24-hour or other nursing care not required in order to be licensed by the State.

(2) **HOME HEALTH CARE OR COMMUNITY-BASED SERVICES.**—If a long-term care insurance policy provides benefits for the payment of specified home health care or community-based services, the policy—

(A) may not limit such benefits to services provided by registered nurses or licensed practical nurses;

(B) may not require benefits for such services to be provided by a nurse or therapist that can be provided by a home health aide or licensed or certified home care worker, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC;

(C) may not limit such benefits to services provided by agencies or providers certified under title XVIII of the Social Security Act; and

(D) must provide, at a minimum, benefits for personal care services (including home health aide and home care worker services as defined by the NAIC) home health services, adult day care, and respite care in an individual's home or in another setting in the community, or any of these benefits on a respite care basis.

(3) **NURSING FACILITY SERVICES.**—If a long-term care insurance policy provides benefits for the payment of specified nursing facility services, the policy must provide such benefits with respect to all nursing facilities (as defined in section 1919(a) of the Social Security Act or until such time as subsequently provided for by the NAIC in establishing uniform language and definitions under section 2715(a)(1)) in the State.

(4) **PER DIEM POLICIES.**—

(A) **DEFINITION.**—For purposes of this title, the term “per diem long-term care insurance policy” means a long-term care insurance policy (or certificate under a group long-term care insurance policy) that provides for benefit payments on a periodic basis due to cognitive impairment or loss of functional capacity without regard to the expenses incurred or services rendered during the period to which the payments relate.

(B) **LIMITATION.**—No per diem long-term care insurance policy (or certificate) may condition, limit or otherwise exclude benefit payments based on the receipt of any type

services from any type providers of long-term care service providers.

(d) **PROHIBITION OF DISCRIMINATION.**—A long-term care insurance policy may not treat benefits under the policy in the case of an individual with Alzheimer's disease, with any related progressive degenerative dementia of an organic origin, with any organic or inorganic mental illness, or with mental retardation or any other cognitive or mental impairment differently from an individual having another medical condition for which benefits may be made available.

(e) **LIMITATION ON USE OF PREEXISTING CONDITION LIMITS.**—

(1) **INITIAL ISSUANCE.**—

(A) **IN GENERAL.**—Subject to subparagraph (B), a long-term care insurance policy may not exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed before the issuance of the policy.

(B) **6-MONTH LIMIT.**—

(i) **IN GENERAL.**—No long-term care insurance policy or certificate issued under this title shall utilize a definition of "preexisting condition" that is more restrictive than the following: The term "preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage of an insured individual.

(ii) **PROHIBITION ON EXCLUSION OF COVERAGE.**—No long-term care insurance policy or certificate may exclude coverage for a loss or confinement that is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of the coverage of the insured individual.

(2) **REPLACEMENT POLICIES.**—If a long-term care insurance policy replaces another long-term care insurance policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

(f) **ELIGIBILITY FOR BENEFITS.**—

(1) **LONG-TERM CARE POLICIES.**—Each long-term care insurance policy shall—

(A) describe the level of benefits available under the policy; and

(B) specify in clear, understandable terms, the level (or levels) of physical, cognitive, or mental impairment required in order to receive benefits under the policy.

(2) **FUNCTIONAL ASSESSMENT.**—In order to submit a claim under any long-term care insurance policy, each claimant shall have a professional functional assessment of his or her physical, cognitive, and mental abilities. Such initial assessment shall be conducted by an individual or entity, meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and

that such individual meets any applicable State licensure and certification requirements. The individual or entity conducting such assessment may not control, or be controlled by, the issuer of the policy. For purposes of this paragraph and paragraph (4), the term "control" means the direct or indirect possession of the power to direct the management and policies of a person. Control is presumed to exist, if any person directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent of the voting securities of another person.

(3) **CLAIMS REVIEW.**—Except as provided in paragraph (1), each long-term care insurance policy shall be subject to final claims review by the carrier pursuant to the terms of the long-term care insurance policy.

(4) **APPEALS PROCESS.**—

(A) **IN GENERAL.**—Each long-term care insurance policy shall provide for a timely and independent appeals process, meeting standards established by the NAIC, for individuals who dispute the results of the claims review, conducted under paragraph (3), of the policyholder's functional assessment, conducted under paragraph (1).

(B) **INDEPENDENT ASSESSMENT.**—An appeals process under this paragraph shall include, at the request of the claimant, an independent assessment of the claimant's physical, cognitive or mental abilities.

(C) **CONDUCT.**—An independent assessment under subparagraph (B) shall be conducted by an individual or entity meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and any applicable State licensure and certification requirements and may not be conducted—

(i) by an individual who has a direct or indirect significant or controlling interest in, or direct affiliation or relationship with, the issuer of the policy;

(ii) by an entity that provides services to the policyholder or certificateholder for which benefits are available under the long-term care insurance policy; or

(iii) by an individual or entity in control of, or controlled by, the issuer of the policy.

(5) **STANDARD ASSESSMENTS.**—Not later than 2 years after the date of enactment of this title, the advisory committee established under section 2701(d) shall recommend uniform needs assessment mechanisms for the determination of eligibility for benefits under such assessments.

(g) **INFLATION PROTECTION.**—

(1) **OPTION TO PURCHASE.**—A carrier may not offer a long-term care insurance policy unless the carrier also offers to the proposed policyholder, including each group policyholder, the option to purchase a policy that provides for increases in benefit levels, with benefit maximums or reasonable durations that are meaningful, to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. A carrier may not offer to a policyholder an inflation protection fea-

ture that is less favorable to the policyholder than one following:

(A) With respect to policies that provide for automatic periodic increases in benefits, the policy provides for an annual increase in benefits in a manner so that such increases are computed annually at a rate of not less than 5 percent.

(B) With respect to policies that provide for periodic opportunities to elect an increase in benefits, the policy guarantees that the insured individual will have the right to periodically increase the benefit levels under the policy without providing evidence of insurability or health status so long as the option for the previous period was not declined. The amount of any such additional benefit may not be less than the difference between—

(i) the existing policy benefit; and

(ii) such existing benefit compounded annually at a rate of at least 5 percent for the period beginning on the date on which the existing benefit is purchased and extending until the year in which the offer of increase is made.

(C) With respect to service benefit policies, the policy covers a specified percentage of the actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) *EXCEPTION.*—The requirements of paragraph (1) shall not apply to life insurance policies or riders containing accelerated long-term care benefits.

(3) *REQUIRED INFORMATION.*—Carriers shall include the following information in or together with the outline of coverage provided under this title:

(A) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. Such comparison shall show benefit levels over not less than a 20-year period.

(B) Any expected premium increases or additional premiums required to pay for any automatic or optional benefit increases, whether the individual who purchases the policy obtains the inflation protection initially or whether such individual delays purchasing such protection until a future time.

(4) *CONTINUATION OF PROTECTION.*—Inflation protection benefit increases under this subsection under a policy that contains such protection shall continue without regard to an insured's age, claim status or claim history, or the length of time the individual has been insured under the policy.

(5) *CONSTANT PREMIUM.*—An offer of inflation protection under this subsection that provides for automatic benefit increases shall include an offer of a premium that the carrier expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(6) *REJECTION.*—Inflation protection under this subsection shall be included in a long-term care insurance policy unless a

carrier obtains a written rejection of such protection signed by the policyholder.

SEC. 2716. NONFORFEITURE.

(a) *IN GENERAL.*—Each long-term care insurance policy (or certificate) shall provide that if the policy lapses after the policy has been in effect for a minimum period (specified under the standards under section 2701(a)), the policy will provide, without payment of any additional premiums, nonforfeiture benefits as determined appropriate by the NAIC.

(b) *ESTABLISHMENT OF STANDARDS.*—The standards under section 2701(a) shall provide that the percentage or amount of benefits under subsection (a) must increase based upon the policyholder's equity in the policy.

SEC. 2717. LIMIT OF PERIOD OF CONTESTABILITY AND RIGHT TO RETURN.

(a) *CONTESTABILITY.*—A carrier may not cancel or renew a long-term care insurance policy or deny a claim under the policy based on fraud or intentional misrepresentation relating to the issuance of the policy unless notice of such fraud or misrepresentation is provided within a time period to be determined by the NAIC.

(b) *RIGHT TO RETURN.*—Each applicant for a long-term care insurance policy shall have the right to return the policy (or certificates) within 30 days of the date of its delivery (and to have the premium refunded) if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

SEC. 2718. CIVIL MONEY PENALTY.

(a) *CARRIER.*—Any carrier, association or its subsidiary that sells or offers for sale a long-term care insurance policy and that—

(1) fails to make a refund in accordance with section 2713(a);
(2) fails to transmit a policy in accordance with section 2713(b);

(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2713;

(4) provides a commission or compensation in violation of section 2713(e);

(5) fails to provide an outline of coverage in violation of section 2715(b)(1); or

(6) issues a policy without obtaining certain information in violation of section 2715(f);

is subject to a civil money penalty of not to exceed \$25,000 for each such violation.

(b) *AGENTS.*—Any agent that sells or offers for sale a long-term care insurance policy and that—

(1) fails to make a refund in accordance with section 2713(a);
(2) fails to transmit a policy in accordance with section 2713(b);

(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2713;

(4) fails to provide an outline of coverage in violation of section 2715(b)(1); or

(5) issues a policy without obtaining certain information in violation of section 2715(f);

is subject to a civil money penalty of not to exceed \$15,000 for each such violation.

PART C—LONG-TERM CARE INSURANCE POLICIES, DEFINITION AND ENDORSEMENTS

SEC. 2721. LONG-TERM CARE INSURANCE POLICY DEFINED.

(a) *IN GENERAL.*—As used in this section, the term “long-term care insurance policy” means any insurance policy, rider or certificate advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity prepaid or other basis, for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes—

(1) group and individual annuities and life insurance policies, riders or certificates that provide directly, or that supplement long-term care insurance; and

(2) a policy, rider or certificates that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

(b) *ISSUANCE.*—Long-term care insurance policies may be issued by—

(1) carriers;

(2) fraternal benefit societies;

(3) nonprofit health, hospital, and medical service corporations;

(4) prepaid health plans;

(5) health maintenance organizations; or

(6) any similar organization to the extent they are otherwise authorized to issue life or health insurance.

(c) *POLICIES EXCLUDED.*—The term “long-term care insurance policy” shall not include any insurance policy, rider or certificate that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With respect to life insurance, such term shall not include life insurance policies, riders or certificates that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(d) *APPLICATIONS.*—Notwithstanding any other provision of this title, this title shall apply to any product advertised, marketed or offered as a long-term insurance policy, rider or certificate.

SEC. 2722. CODE OF CONDUCT WITH RESPECT TO ENDORSEMENTS.

Not later than 1 year after the date of enactment of this title the NAIC shall issue guidelines that shall apply to organizations and associations, other than employers and labor organizations that do

not accept compensation, and their subsidiaries that provide endorsements of long-term care insurance policies, or that permit such policies to be offered for sale through the organization or association. Such guidelines shall include at minimum the following:

(1) In endorsing or selling long-term care insurance policies, the primary responsibility of an organization or association shall be to educate their members concerning such policies and assist such members in making informed decisions. Such organizations and associations may not function primarily as sales agents for insurance companies.

(2) Organizations and associations shall provide objective information regarding long-term care insurance policies sold or endorsed by such organizations and associations to ensure that members of such organizations and associations have a balanced and complete understanding of both the strengths and weaknesses of the policies that are being endorsed or sold.

(3) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the manner in which such policies and the insurance company issuing such policies were selected. If the organization or association and the insurance company have interlocking directorates, the organization or association shall disclose such fact to their members.

(4) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support that the organization or association receives) from the endorsement or sale of the policy to its members.

(5) The Boards of Directors of organizations and associations selling or endorsing long-term care insurance policies, if such organizations and associations have a Board of Directors, shall review and approve such insurance policies, the compensation arrangements and the marketing materials used to promote sales of such policies.

PART 4—MISCELLANEOUS PROVISIONS

SEC. 2731. FUNDING FOR LONG-TERM CARE INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE.

(a) **IN GENERAL.**—The Secretary, acting through the Public Health Service, may award grants to States, and national organizations with demonstrated experience in long-term care insurance, for the establishment of programs to provide information, counseling, and assistance relating to the procurement of adequate and appropriate long-term care insurance.

(b) **APPLICATION.**—To be eligible to receive a grant under subsection (a), a State or national organization shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including

a description of the program for which the State or organization intends to use the amounts provided under the grant.

(c) **AUTHORIZATION OF APPROPRIATIONS.**—

(1) **IN GENERAL.**—There are authorized to be appropriate for grants to States under subsection (a), \$10,000,000 for each of the fiscal years 1993 through 1995.

(2) **NATIONAL ORGANIZATIONS.**—There are authorized to be appropriate for grants to national organizations under subsection (a), \$1,000,000 for each of the fiscal years 1993 through 1995.

SEC. 2732. DEFINITIONS.

As used in this title:

(1) **AGENT.**—The term “agent” means—

(A) prior to 2 years after the date of enactment of this Act, an individual who sells or offers for sale a long-term care insurance policy subject to the requirements of this title and is licensed or required to be licensed under State law for such purpose; and

(B) after the date referred to in subparagraph (A), an individual who meets the training and certification requirements established under section 2712(f).

(2) **ASSOCIATION.**—The term “association” includes the association and its subsidiaries.

(3) **CARRIER.**—The term “carrier” means any person that offers a health benefit plan, whether through insurance or otherwise, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a self-insured carrier, a reinsurance carrier, and a multiple employer welfare arrangement (a combination of employers associated for the purpose of providing health benefit plan coverage for their employees).

TITLE [XXVII] XXVIII—MISCELLANEOUS

GIFTS

SEC. [2701] 2801. (a) * * *

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USE OF IMMIGRATION STATION HOSPITALS

SEC. [2702] 2802. * * *

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MONEY COLLECTED FOR CARE OF PATIENTS

SEC. [2703] 2803. * * *

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TRANSPORTATION OF REMAINS OF OFFICERS

SEC. [2704] 2804. * * *

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SEC. [2708] 2808. * * *

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SEC. [2712] 2812. * * *

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RECOVERY

SEC. [2713] 2813. (a) * * *

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USE OF FISCAL AGENTS

SEC. [2714] 2814. (a) * * *

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